

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9-5-2

## CERTIFICATE OF DEATH

115192

Reg. Dist. No. 254

## 1. PLACE OF DEATH:

County..... Queen Anne

City or town..... Queenstown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all of life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Sarah Anne Anthony

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

Female

White

Widow

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

6.(c) If alive, give age .....

years

Aug. 25 - 1853

8. AGE:

Years

Months

Days

If less than one day

90

8

16

hrs.

min.

9. Birthplace.....

Baltimore, Md.

(Town, county, and state)

10. Usual occupation.....

Housewife

11. Industry or business

MOTHER FATHER

12. Name.....

Isaac Difore

13. Birthplace

Baltimore, Md.

unknown

14. Maiden name.....

15. Birthplace

"

16. Informant.....

Mrs. Margaret A. Matzdorf

Address

Queenstown, Md.

17. Burial.....

Date thereof..... May 13, 46

(month)

(day)

(year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory

St. Peter's Church Yard

Location

Queenstown, Md.

18. Funeral director.....

Address

Castor, Maryland

May 13, 1946

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Md.

County.....

Queen Anne

City or town..... Queenstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 11, 1946, at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h..... alive on.....

19.....

Immediate cause of death.....

Found dead in bed =

Evidently a heart attack -

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur? .....

(City or town)

(County)

(State)

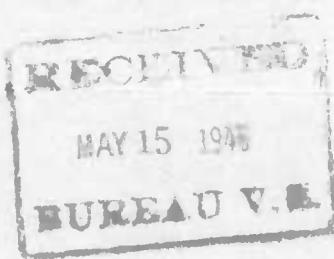
Injured at home, farm, industry, public place (where?) .....

Means of injury.....

Injured at work?

23. SIGNATURE

W. Henry Fisher  
Deputy Coroner & P. of other  
Centreville, Md. Date signed 5/11/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1640

## CERTIFICATE OF DEATH

Reg. Dist. No. 151854

## 1. PLACE OF DEATH:

County Queen Anne's  
City or town Ocean City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? see his wife

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

William Bedford

## 4. Sex

## 5. Color or race

## 6.(a) Single, married, widowed, or divorced

Male

Colored

widowed

## 6.(b) Name of husband or wife

deceased

Ida Bedford

8.(c) If alive, give age years

## 7. Birth date of deceased (mo., day, yr.)

Sept - 28 - 1870

## 8. AGE:

Years Months Days If less than one day

75

8

0

hrs.

min.

## 9. Birthplace

Ocean City, Md.

(Town, county, and state)

## 10. Usual occupation

Laborer

## 11. Industry or business

Canning Factory

## MOTHER FATHER

## 12. Name

Abraham Bedford

## 13. Birthplace

Ocean City, Maryland

(Town, county, and state)

## 14. Maiden name

Annie S.

## 15. Birthplace

Ocean City, Maryland

## 16. Informant

Perry Hardy

## Address

Ocean City, Md.

## 17. Burial

(Burial, cremation, or removal. Which?) Date thereof May 29 - 46

(month) (day) (year)

## Cemetery or crematory

Ocean City

## Location

Royal Cemetery, Md.

(City or town)

(County) (State)

## 18. Funeral director

T. S. Fisher

## Address

Centreville, Maryland

## 19. May 28 1946

Helen M. Addridge

## (Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's

City or town Ocean City

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

216-12-1254

## MEDICAL CERTIFICATION

May 27 1946 at 5 a.m.

2d. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death Suicide DURATION

He shot himself with a shot gun -

Due to

Due to

Other conditions He has been sick for last 4 days.

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur (City or town) (County) (State)

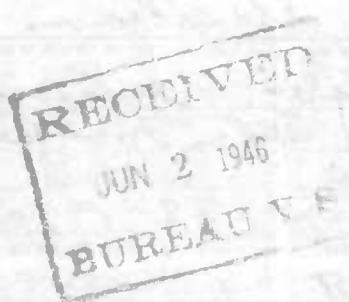
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. J. Fisher

deputy coroner physician other

Address Centreville, Md. Date signed 5/27/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

15094

Reg. Dist. No.

251

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

6th life

Hospital, institution, or street address where death occurred: \_\_\_\_\_

How long in hospital or institution?.....

## 3. (a) FULL NAME

Audrey Frances Buttler

4. Sex

Color of race

6.(a) Single, married, widowed, or divorced

S

6.(b) Name of husband or wife: \_\_\_\_\_

7. Birth date of deceased (mo., day, yr.)

Aug 23 1944

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

1

9

5

hrs. min.

9. Birthplace: \_\_\_\_\_

Md Barclay Md

(Town, county, and state)

10. Usual occupation: \_\_\_\_\_

Challif

11. Industry or business

MOTHER FATHER

12. Name: \_\_\_\_\_

Wm Edmund Buttler

13. Birthplace

Church Hill Md

14. Maiden name

Audrey Frances Dickerson

15. Birthplace

Barclay Md

16. Informant: \_\_\_\_\_

Audrey Frances Dickerson

Address

Barclay Md

17. Burial (Burial, cremation, or removal. Which?)

Burial Date thereof: May 30 1946

(month)

(day)

(year)

Cemetery or crematory

Barclay Cem

Location

Barclay Md

18. Funeral director

Edgar L. Lane

Address

Church Hill Md.

19. May 28 1946

Date rec'd by registrar

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Md.

County.....

Md.

City or town.....

Barclay

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 28

19

46 at 9:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 27

19 46 to

May 28

19 46

and that I last saw her alive on May 27

19 46

Immediate cause of death

Acute dry bronchitis - pneumonia

DURATION

Due to: Dry bronchitis - pneumonia

Due to: \_\_\_\_\_

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

C. M. McCalfe

M. D. or other

Address: Laurel Valley Md Date signed: May 20 1946



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 180

05095

## CERTIFICATE OF DEATH

Reg. Distr. No.

254

1. PLACE OF DEATH: *Green Anne*  
 County.....  
 City or town..... *near Grasonville Md*  
(If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *all of life*  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State..... *Md* County..... *Green Anne*  
 City or town..... *near Grasonville*  
(If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
(If rural, give LOCATION)

3. (a) FULL NAME  
*Wm Thomas Couper*

3. (b) Social Security Number

4. Sex *Male* 5. Color or race *col-* 6.(a) Single, married, widowed, or divorced  
*Single*

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.) *Aug 12 1900* 6.(c) If alive, give age..... years

8. AGE: Years *45* Months *8* Days *30* if less than one day  
*hrs. min.*

9. Birthplace..... *Grasonville Md*  
(Town, county, and state)

10. Usual occupation..... *Optician*

11. Industry or business..... *Robt J. Couper*

FATHER 12. Name..... *Robt J. Couper*  
 13. Birthplace..... *Grasonville Md*

MOTHER 14. Maiden name..... *Harriett Willman*  
 15. Birthplace..... *Grasonville Md*

16. Informant..... *Paymond Couper*  
 Address..... *Grasonville Md*

BURIAL 17. Burial..... *May 12-46*  
(Burial, cremation, or removal. Which?) Date thereof..... *(month) (day) (year)*

Cemetery or crematory..... *Progress Chapel Cemetery*  
 Location..... *Grasonville Md*

18. Funeral director..... *John A. Willman*  
 Address..... *Edetod Md*

19. Date record by registrar..... *May 12 1946* Helen M. Aldridge  
(Date record by registrar) Registrar..... *SC*

## MEDICAL CERTIFICATION

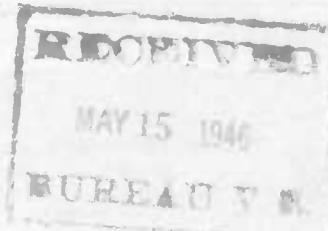
20. DATE OF DEATH *May 11 1946* at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw h..... alive on..... 19.....

Immediate cause of death..... *Burned to death - house caught fire from oil stove -* DURATION



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 19

## CERTIFICATE OF DEATH

05096

Reg. Dist. No. 352

1. PLACE OF DEATH:  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Infant

8.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

May 1 - 1946

6.(c) If alive, give age..... years  
8. AGE: Years      Months      Days      If less than one day9. Birthplace.....  
(Town, county, and state)

10. Usual occupation.....

11. Industry or business

FATHER 12. Name.....

13. Birthplace.....

MOTHER 14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Burial, cremation, or removal (which)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date reg'd by registrar

May 10 - 1946

Elise Armstrong

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
State..... County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 9 1946 at 9a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 1946, to May 9 - 1946, and that I last saw her alive on May 8, 1946.

Immediate cause of death.....

Premature birth

Due to.....

Due to.....

Other conditions..... Congenital Weakness

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

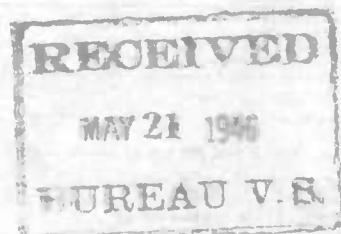
Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address..... Date signed 5/10-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 23

## CERTIFICATE OF DEATH

05097

Reg. Dist. No. 251

## 1. PLACE OF DEATH:

Queen Anne

County

1101 Chestertown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Christopher A. Faulkner

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

m w

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Oct 15 - 1925

8. (c) If alive, give age

years

8. AGE:

Years Months Days If less than one day

20

7

15

hrs.

min.

9. Birthplace

Caroline Co.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Edgar S. Faulkner

12. Name

Edgar S. Faulkner

13. Birthplace

T. J. Co. Ind.

14. Maiden name

Ella M. Starkey

15. Birthplace

Caroline Co. Ind.

16. Informant

Mrs. Ella Faulkner

Address

Chestertown Ind P.F.D.

17. Burial

Date thereof June 2 - 1946

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Hillsboro

Location

Hillsboro Md.

18. Funeral director

Edgar S. Faulkner

Address

Chief of Staff M.

19. Date rec'd by registrar

June 2 1946

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County Queen Anne

City or town

near Chestertown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 30 1946 at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw h. alive on

19...

Immediate cause of death

Drowning

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 5/30-46

Where did injury occur? (City or town) (County) (State)

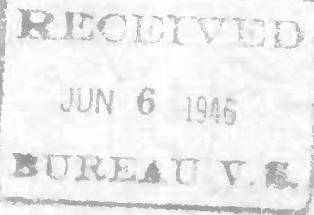
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Henry Fisher  
Sergeant Police Department  
Curtinville W. Va.  
Date signed 6/2-46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

05098

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

## 1. PLACE OF DEATH

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in Hospital or Institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

1878

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof (month) (day) (year)

Cemetery or crematory

Puthsburg, Pa. Home

Location

Puthsburg, Maryland

18. Funeral director

Mrs. Wm. B. Shirley

Address

Centerville, Md.

19. May 25-1946

(Date rec'd by registrar)

Elie Armstrong Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

5-25-1946

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1946 to May 25-1946

and that I last saw h. alive on

5-25-1946

Immediate cause of death

Death

DURATION

Due to Automobile accident hit by automobile

Cause

Due to

Typhoid

Other conditions

Recovery

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Accidents Date of May 15, 1946

Where did injury occur? In Centerville, Queen Anne, Maryland (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public place

Means of injury hit by automobile Injured at work

23. SIGNATURE

M. D. or other

Address

Date signed

RECEIVED  
JUN 2 1946  
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B.C.)

05099

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

## 1. PLACE OF DEATH:

County Queen Anne's  
City or town Crossonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 54 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Charles Robert Stafford

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

white

married

6. (b) Name of husband or wife Minerva Alice Greene

7. Birth date of deceased (mo., day, yr.) Feb 28 - 1863

6. (c) If alive, give age 73 years

8. AGE: Years Months Days If less than one day

83

2

26

hrs.

min.

9. Birthplace Tidewater Co., Maryland

(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business Retired

12. Name Theodore Stafford

13. Birthplace Tidewater Co., Maryland

14. Maiden name Eliza Faulkner

15. Birthplace Tidewater Co., Maryland

16. Informant Mrs. John C. Cole

Address Queenstown, Maryland

17. Burial Date thereof May 27-46

(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Chesterfield

Location Centreville, Maryland

18. Funeral director Barton Scov

Address Centreville, Maryland

19. May 27 1946 Hein M. Cedric Jr.  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne's

City or town Crossonville (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

WW

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

2D. DATE OF DEATH

May 24 1946 at 11:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1946 to May 26 1946

and that I last saw him alive on May 24 1946

Immediate cause of death

Cordice Dilatation

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

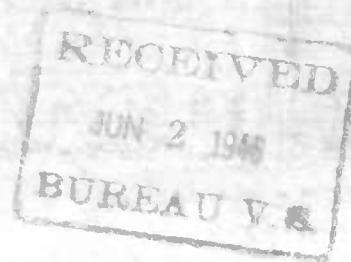
Means of injury

Injured at work?

23. SIGNATURE

W. Cho E. Jones M. D. or other  
Address Glenwood Date signed May 25/46

RECEIVED BY THE STATE GUARD  
U.S. GOVERNMENT



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *MD*

## CERTIFICATE OF DEATH

05100

Rng. Diat. No. 252

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years      Months      Days      If less than one day  
                  10            0            0            hrs.            min.8. Birthplace  
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial  
(Burial, cremation, or removal. Which?) Date thereof May 28-46  
(monthly) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 5-28-1946  
(Date rec'd by registrar)

Registrar

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 20 1946 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1 1945 to May 23 1946, and that I last saw her alive on May 24 1946.

Immediate cause of death

Chronic Val. disease

Due to: A de mentia

Due to:

Other conditions Hypertension

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

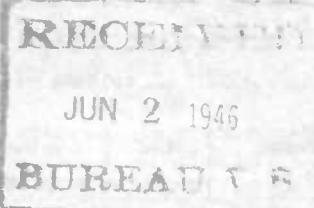
H. J. West

M. D. or other

Address Date signed 5/28/46

STANISLAW TWARDOWSKI STATE LIBRARY

HONG KONG LIBRARY



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

Reg. Dist. No. 15101 252

## 1. PLACE OF DEATH:

County Dungen Annie's  
City or town Centreville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address where death occurred:

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Alexander Watson

## 4. Sex

Male Colored Widowed

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

## 6. (b) Name of husband or wife

Marianne Philip Watson

## 7. Birth date of deceased (mo., day, yr.)

Years 87 Months 0 Days 12 It less than one day

## 8. (c) If alive, give age years

May 6 - 1859

## 8. AGE:

Years 87 Months 0 Days 12 hrs. min.

## 9. Birthplace

Centreville 200 Maryland

(Town, county, and state)

## 10. Usual occupation

## 11. Industry or business

## MOTHER FATHER

Name James Watson

## 13. Birthplace

Centreville, Maryland

## 14. Maiden name

Susan ?

## 15. Birthplace

Don't know

## 16. Informant

Ruth Dolores Watson

## Address

Centreville Maryland

## 17. Burial

Date thereof May 21-46  
(Burial, cremation, or removal. Which?) Date (month) (day) (year)

## Cemetery or crematory

Chesterfield

## Location

Centreville, Maryland

## 18. Funeral director

Barton Bros

## Address

Centreville, Maryland

## 19. 5-21-46

Date rec'd by registrar Elsie Armstrong

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Centreville

(If outside city or town limits, write RURAL and give nearest town)

## Street No. \_\_\_\_\_

(If rural, give LOCATION)

20

## 2.(a) If veteran, name war. \_\_\_\_\_

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

May 18-1946 at 49

I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 18-1946 to May 18-1946 and that I last saw him alive on May 16-1946

## Immediate cause of death

Heart

## Due to

Stroke

## Due to

Stroke

## Other conditions

(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

H. J. Watson

M. D. or other

Address Centreville, MD Date signed 5/20/46

